MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

ASSISTANT APPROVAL REQUEST

RETURN BOTH COPIES TO THE LOCAL SECTION FOR CHILD CARE REGULATION OFFICE

NAME OF FACILITY	FACILITY OWNER	FACILITY DVN
ADDRESS (STREET, CITY, STATE, ZIP)		TELEPHONE NUMBER ( )

PROPOSED ASSISTANT (ADULT)

NAME	TELEPHONE NUMBER ( )	DATE OF BIRTH
ADDRESS (STREET, CITY, STATE, ZIP)		

TWO REFERENCES FOR PROPOSED ASSISTANT (NOT RELATED TO THE ASSISTANT)

NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP)	
NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP)	

BACKGROUND CHECK (Required for all assistants.)

COPY OF BACKGROUND CHECK RESULTS (NOT OLDER THAN 12 MONTHS) IS ATTACHED. ☐ YES ☐ NO

WORK STATUS

EMPLOYED OR VOLUNTEERS MORE THAN 20 HOURS PER MONTH. ☐ YES ☐ NO

USED TO MEET CAREGIVER/CHILD RATIOS FOR INFANTS AND TODDLERS ☐ YES ☐ NO

AGREEMENT SECTION

BY MY SIGNATURE BELOW, AS LICENSEE, I AGREE:

- To have a copy of child care home licensing rules available and to assure that any assistant employed or volunteering in my facility has reviewed and is knowledgeable of those rules.
- To have an assistant's required medical and TB report on file at my facility within 30 days of first day of work that exceeds 20 hours per month.
- To maintain documentation of training for assistants who work more than 20 hours per month, as required.
- To maintain accurate daily attendance records on file at my facility for all caregivers.

SIGNATURE

OWNER/LICENSEE/DESIGNEE	DATE

OFFICE USE ONLY

BACKGROUND CHECK RESPONSE DATE	BACKGROUND CHECK RESPONSE RECEIVED DATE

ASSISTANT APPROVED ☐ YES ☐ NO

COMMENTS

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CHILD CARE SPECIALIST	DATE